SHELBY COUNTY GOVERNMENT

Employee/Retiree Health Care Plans Enrollment/Change Form

Insured and/or Administered by
Connecticut General Life Insurance Company
CIGNA HealthCare of Tennessee, Inc.

CIGNA®

(Please complete this form in its entirety)

A

☐ OPEN ENROLLMENT ☐ CHANGE
☐ NEW ENROLLMENT ☐ REINSTATE

EFFECTIVE DATE OF ADD/CHANGE/ CANCELLATION (MM/DD/CCYY)

EMPLOYER NAME: **SHELBY COUNTY GOVERNMENT**

EMPLOYER ADDRESS: **160 N. MAIN ST., SUITE 949, MEMPHIS, TN 38103**

DEPT. NAME

DATE OF HIRE (MM/DD/CCYY)

BRANCH (OFFICE USE ONLY)

CIGNA ACCOUNT NO.: **3209876**

TYPE OF CHANGE:

☐ **Add Dependent(s) *** Date: _____
☐ **Cancel Dependent(s) *** Last Date of Coverage: _____
☐ **Survivor**
*** List Full Names in Section B**

☐ **Name Change: From** _____ **To** _____
☐ **COBRA**
☐ **Other** _____

MEDICAL BENEFIT OPTIONS

☐ **OAP/In-Network (OAPIN)**
☐ Single
☐ Family

☐ **OAP/PPO (OAP)**
☐ Single
☐ Family

☐ **CHOICE FUND HRA**
☐ Single **(HRA1)**
☐ Single + One **(HRA2)**
☐ Family **(HRA3)**

B

EMPLOYEE • RETIREE

EMPLOYEE/RETIREE NAME *(Last)* *(First)* *(M.I.)*

SOCIAL SECURITY NO.

DATE OF BIRTH (MM/DD/CCYY)

GENDER ☐ M ☐ F

STATUS ☐ Active ☐ Retired

HOME PHONE ( )

WORK PHONE ( )

E-MAIL ADDRESS

ADDRESS *(Street)* *(City)* *(State)* *(Zip Code)*

DEPENDENT INFORMATION Last Name / First Name / M.I.	DEPENDENT SOCIAL SECURITY NO.	DATE OF BIRTH MM DD CCYY	GENDER	PROOF OF RELATIONSHIP ATTACHED? * Yes No
Spouse			☐ M ☐ F	☐ ☐
Dependent * Relationship			☐ M ☐ F	☐ ☐
Dependent * Relationship			☐ M ☐ F	☐ ☐
Dependent * Relationship			☐ M ☐ F	☐ ☐

*** DEPENDENTS -** Up to age 26. Adult children married or unmarried and living or not living with parent qualify for this coverage. Age 19 to 26 children must provide copy of birth certificate and/or other pertinent documentation to establish eligibility for enrollment. If totally disabled prior to age 26, attach proof of disability for eligibility review. Proof of relationship is required to add dependent less than 26 and/or spouse who are not currently enrolled on your medical coverage.

C

☐ **CANCEL/DECLINE COVERAGE:** As a new employee, I attest that I have other medical coverage and wish to decline, or as a current employee, cancel due to a qualifying event/status change. By checking the decline/cancel coverage box and signing this form, I understand that I can only enroll during open enrollment or re-enroll if I have a qualifying event/status change. (Proof of other coverage is required when re-enrolling due to a qualifying event/status change and must be attached/provided within 30 days of the change.)

D

OTHER HEALTH CARE COVERAGE:

Do you or your dependents have other health insurance under a group plan, HMO, or Medicare? ☐ Yes ☐ No *If yes, please provide the following:*

NAME OF PERSON COVERED	SOCIAL SECURITY NO.	EFFECTIVE DATE	MEDICARE Part A	MEDICARE Part B	MEDICAID	OTHER INSURANCE CARRIER
			☐	☐	☐	☐
			☐	☐	☐	☐

E

SIGNATURE - I have read this form and certify that all statements contained are true and correct to the best of my knowledge. I understand any material misrepresentation will result in the cancellation of my coverage and the denial of claims plus reimbursement to the health plan of any benefit payments. I understand that if my coverage contains limitations on pre-existing conditions that these limitations will be stated in the plan. I accept the provisions on the reverse side of this form which I have read and understand.

EMPLOYEE'S SIGNATURE

DATE

FOR OFFICE USE ONLY

EIN

COMMENTS

INPUT BY

DISTRIBUTION: Original - Shelby County Government **Employee -** Please make a copy for your records.

(OVER)

PROVISIONS

- "CIGNA HealthCare" refers to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these subsidiaries and not by CIGNA Corporation. These subsidiaries include Connecticut General Life Insurance Company, Tel-Drug, Inc. and its affiliates, CIGNA Behavioral Health, Inc., Intracorp, and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc.
- I agree, for myself and my dependents, that, in the event any health services provided are the primary responsibility of any other party by way of other group health coverage or by the act or omission of another person to fully inform the healthplan and will execute such assignments, liens or other documents which may be necessary to enable the healthplan to recover the value of the services provided. I further agree that in the event I or any of my dependents collect benefits or damages from any other party who has primary responsibility for services provided by the healthplan, I will immediately reimburse the healthplan to the extent of services provided, to the extent permitted by state law.

FRAUD WARNING

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

AUTHORIZATION TO DEDUCT CONTRIBUTIONS

I authorize deductions from my earnings of the required contributions, if any, toward the cost of the coverage. This authorization applies only if employee contributions are required.

SPECIAL PROVISION FOR EMPLOYERS WITH SECTION 125 PLANS

By allowing an individual to enroll in the Insurance Plan other than during the open enrollment period, CIGNA HealthCare or Connecticut General Life Insurance Company does not waive any terms of its contract. Further, by allowing an individual to enroll in the Insurance Plan other than during an open enrollment period, CIGNA HealthCare or Connecticut General Life Insurance Company does not thereby express any opinion regarding the appropriateness of the change under Section 125 of the Internal Revenue Code or the terms of the employer’s Section 125 Plan.